83-797

No. -

Office - Supreme Court, U.S.
FILED
NOV 9 1983
ALEXANDER L. STEVAS,
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1983

MEMORIAL HOSPITAL, et al.,

Petitioners,

v.

MARGARET M. HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

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November 9, 1983

QUESTION PRESENTED

1. Where a regulation of the Secretary of Health and Human Services prohibiting reimbursement for bedside telephones, promulgated without benefit of hearings or public comment, is found inconsistent with established fact and legislative history, may the appellate court abdicate its function of judicial review and disregard the evidence because of a perceived judicial deference due agency action?

PARTIES TO THE PROCEEDING

Memorial Hospital, Walker Memorial Hospital, Boca Raton Community Hospital, Inc., Bethesda Memorial Hospital, Manatee Memorial Hospital, Cape Canaveral Hospital, Halifax Hospital Medical Center, Mease Hospital & Clinic, Waterman Memorial Hospital, Holy Cross Hospital, Inc., North Ridge General Hospital, Inc., Fort Myers Community Hospital, Lee Memorial Hospital, Alachua General Hospital, The Heart of Florida Hospital, Hollywood Medical Center, Memorial Hospital, Baptist Medical Center, Jacksonville General Hospital, Memorial Hospital of Jacksonville, Methodist Hospital, St. Vincent's Medical Center, Lake Wales Hospital, John F. Kennedy Memorial Hospital, Sun Coast Osteopathic Hospital, Florida Medical Center Hospital, Fishermen's Hospital, Inc., Jackson Hospital, American Hospital, Baptist Hospital of Miami, Inc., Cedars of Lebanon Hospital, Miami-Dade General Hospital, North Shore Hospital, Pan American Hospital, St. Francis Hospital, South Shore Hospital, Naples Community Hospital, Inc., Fish Memorial Hospital, Osteopathic General Hospital, Munroe Memorial Hospital, Florida Hospital, Baptist Hospital, Sacred Heart Hospital of Pensacola, University Hospital & Clinic, Doctors General Hospital, St. Joseph Hospital of Port Charlotte, Inc., Medical Center Hospital, Wuesthoff Memorial Hospital, St. Anthony's Hospital, Inc., Seminole Memorial Hospital, Doctors Hospital of Sarasota, Inc., Memorial Hospital, South Miami Hospital, Bradford County Hospital, Martin Memorial Hospital, Tallahassee Memorial Hospital, University Community Hospital, Jess Parrish Memorial Hospital, Venice Hospital, Indian River Memorial Hospital, Memorial Hospital, Providence Hospital, Jackson Memorial Hospital.

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

The petitioners, Memorial Hospital, *et al.*, respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eleventh Circuit, dated June 6, 1983. The Court of Appeals reversed in part and affirmed in part the judgment of the United States District Court for the Middle District of Florida.

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 706 F.2d beginning at page 1138 and is reproduced in the appendix to this Petition, commencing at page 1a. The opinion of the United States District Court for the Middle District of Florida is reproduced in the appendix, commencing at page 1b.

JURISDICTION

The judgment of the Court of Appeals for the Eleventh Circuit was entered on June 6, 1983. A timely petition for rehearing in banc was denied on August 12, 1983, and this petition for certiorari was filed within ninety days of that date. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

United States Code, Title 42:

§ 1395x(b). The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital –

(1) bed and board;

(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements;

§ 1395x(v)(1)(A). [Definition of "reasonable costs" thus reimbursable pursuant to the Medicare program].

The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; . . . . In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national orgnizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be

borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

STATEMENT OF THE CASE

The basis for federal jurisdiction in the court of first instance, the United States District Court for the Middle District of Florida, was 42 U.S.C. § 1395*oo*(f).

Under Part A of the Medicare program, hospitals that have executed an agreement with the Secretary[1] pursuant to 42 U.S.C. § 1395cc, and which meet the other conditions of participation for Medicare providers prescribed at 42 C.F.R. § 405.101 *et seq.*, are reimbursed the lesser of their charges or their reasonable costs incurred in providing covered services to Medicare beneficiaries. 42 U.S.C. § 1395f. Under 42 U.S.C. § 1395d(a) covered services encompass "inpatient hospital services," which are defined at 42 U.S.C. § 1395x(b) to include bed and board, nursing medical social services and such "drugs . . . supplies, appliances, equipment . . . and other diagnostic or therapeutic items or services . . . as are ordinarily furnished to inpatients by such hospital. . . ." The term "reasonable cost" of such services is defined at 42 U.S.C. § 1395x(v)(1)(A) to mean "the *cost actually incurred*, excluding therefrom any part of incurred cost found to be unnecesssary in the efficient delivery of needed health services..." (Emphasis added).

Petitioners Memorial Hospital, *et al.* (hereinafter, the "Hospitals"), are sixty-two short-term acute care general hospitals. They provide all their patients (private, Medicare and indigent) with a bedside telephone as part of their basic care. It is used by physicians and hospital personnel for medical

[1]Originally the Secretary of Health, Education and Welfare, now the Secretary of Health and Human Services, referred to hereinafter as "the Secretary."

purposes and by patients for their personal use and for communicating with hospital personnel. The multiplicity of uses for the bedside telephone is uncontradicted by the Secretary. In addition to the most important hospital usage of alerting the cardiac resuscitation team in the event of a cardiac arrest or other cardio-pulmonary emergency, patient telephones are used by hospital personnel such as inhalation therapy personnel, physical therapy personnel, patient transport personnel, and administrative personnel in the normal course of their duties. R. 802-830, 1007-1020. Patient usage of the bedside telephone includes not only telephone communications with friends, family and loved ones outside the hospital, but also includes communicating with hospital administrative personnel such as the hospital ombudsman, admitting and discharge personnel, and social workers. R. 1010-1014.

The Medicare statute requires the Secretary to reimburse hospitals for reasonable costs incurred in providing "therapeutic items or services . . . as are ordinarily furnished to inpatients . . . by such hospital . . . ." 42 U.S.C. § 1395x(b)(3). All but three of the Hospitals requested Medicare program reimbursement for providing the ordinarily furnished and therapeutic telephone services in the same manner that other therapeutic medical costs are paid for. Claimed reimbursement in the amount of $1,238,292 was denied by the private contractors responsible for administering the program. The Hospitals challenged the refusal by appealing to the Secretary's adjudicatory arm, the Provider Reimbursement Review Board. All agree telephones are ordinarily furnished. More importantly, the Board found that patient telephones have therapeutic value. Appendix at 8b-9b. Despite this factual finding, the Board concluded it was bound to enforce the regulation prohibiting reimbursement for patient telephones, 42 C.F.R. § 405.310(j)(1982). Appendix at 9b. The Board's conclusion that the bedside telephone has measurable therapeutic value was based upon voluminous and uncontested testimony. The Secretary, acting through the Administrator of the Health Care Financing Administration, did not disturb the Board's factual finding of therapeutic value, and allowed the Board's legal conclusion denying reimbursement to stand by declining to review the decision under 42 U.S.C. § 1395*oo*(f).

Upon cross-motions for summary judgment, United States District Judge Hoffman found that neither he nor the Board had jurisdiction to reveiw the Secretary's regulatory decision that bedside telephones were personal comfort items and thus not reimbursable.[2] The United States Court of Appeals for the Eleventh Circuit overruled the district court's decision pertaining to jurisdiction and attempted to address the merits of the bedside telephone issue. Appendix at 5a. Instead of remanding the question of the telephone regulation's validity to the trial court, the Eleventh Circuit, on a record virtually devoid of any explanation for the rule, declared it not inconsistent with the Medicare Act. The sole basis for this conclusion was deference to the agency position. Appendix at 7a.

The Hospitals contend that the Secretary has acted in contravention of the Medicare statute by refusing to reimburse them for a service that the Provider Reimbursement Review Board has found both ordinary and therapeutic. They further contend that resolution of this dispute by the Eleventh Circuit through deference to the agency position without analysis and in the face of contrary established fact and legislative history violates the Hospitals' right to judicial review.

REASONS FOR GRANTING THE WRIT

I.

The Degree of Deference the Eleventh Circuit Accorded the Secretary's Regulation Pertaining to Patient Telephones Is Inconsistent with Several Recent Decisions of This Court and the Court of Appeals for the District of Columbia Circuit.

The Hospitals routinely supply bedside telephones to their patients. They seek Medicare program reimbursement for the pro rata cost of supplying these telephones to Medicare beneficiaries based upon the Medicare patient utilization of the hospital. The Medicare program requires reimbursement of

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[2]The Hospitals combined their challenge to the denial of reimbursement for bedside telephone costs with a claim for reimbursement for the Medicare portion of funds expended in providing agency mandated free care to the indigent under the Hill-Burton program. The district court's decision in favor of the Hospitals on the indigent care issue was reversed, but that question is not presented in this Petition.

all therapeutic hospital services regularly provided to patients, 42 U.S.C. § 1395x(b)(3), and the regularly provided bedside telephones have proven therapeutic value. In spite of this, the Eleventh Circuit accorded total and unexplained deference to a seventeen-year-old regulation declaring telephones non-therapeutic and thus not reimbursable. 42 C.F.R. § 405.310(j)(1982). The court below, in conflict with several decisions of this Court, has sanctioned a regulation which is arbitrary, capricious, has no rational basis, and is an irrebutable presumption inconsistent with established fact.

A. The Secretary Does Not Have Discretion to Promulgate Rules which Contravene Established Fact.

While this Court has repeatedly ruled that the judiciary is not to second-guess Executive branch administrators, neither are the courts bound by legislative type regulations, such as 42 C.F.R. § 405.310(j)(1982), where the agency action can be shown to be arbitrary and capricious or an abuse of discretion. *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944). The regulation at issue was promulgated pursuant to Congressional mandate and the Hospitals thus accept the applicability of the more lenient "arbitrary and capricious" standard. The Medicare statute left to the Secretary definition of what items and services are for "personal comfort" and thus not subject to reimbursement. 42 U.S.C. § 1395y(a)(6). Utilizing the so-called "benefits exception" of the Administrative Procedures Act, 5 U.S.C. § 553(a)(2), the Secretary promulgated the rule without opportunity for debate or criticism by the public or health care providers. 31 Fed. Reg. 13534 (1966). As a result, the only administrative record available to the court below was the Board's expression of doubt as to the validity of the telephone regulation. This Court has declared a rule to be arbitrary and capricious if the agency: "[1] has relied upon factors which Congress has not intended it to consider, [*or*, 2] entirely failed to consider an important aspect of the problem, [*or*, 3] offered an explanation for its decision that runs counter to the evidence before the agency, or [4] is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Manufacturers Ass'n v. State Farm Mutual*, _____ U.S. _____, _____, 103 S. Ct. 2856, 2867 (1983).

The court below rejected the Secretary's preliminary contention that the regulation was immune from judicial review. However, there is no indication that either the district or circuit court examined the merits of the regulation at all, let alone adhered to the standards quoted above. Specifically, the decision shows no consideration of whether the Secretary "failed to consider an important aspect of the problem" and whether the arguments of the Secretary ran "counter to the evidence before the agency." *Id.* In fact, the courts below had virtually no official explanation or rationale for the regulation. The only medical evidence adduced in this case, which the Secretary's own Provider Reimbursement Review Board found convincing, was that bedside telephones *have* measurable therapeutic value. While the district court was inclined to agree with this conclusion (Appendix at 9b), it construed the scope of judicial review far too narrowly, concluding that neither it nor the Board could question the 1966 rule. The Eleventh Circuit rejected the Secretary's restrictive jurisdictional argument, but went on to find the rule itself valid. This acquiescence in agency action, which is utterly at odds with the evidence, is manifestly inconsistent with *Motor Vehicle Manufacturers*. Because the Secretary adduced no medical evidence whatever in support of the blanket exclusion, it was impossible for the court below to make even the most cursory examination of the statutory underpinning for the regulation prohibiting reimbursement for bedside patient telephones. The implications of judicial acceptance of a rule without foundation are far-reaching. Following the Eleventh Circuit's deference position to its logical conclusion, the Secretary could, without any explanation, declare half the cost of nursing services, which are included as allowed costs at section 1395x(b)(2), to be for "personal comfort." For reasons not articulated by the court below, such action would not be subject to judicial review. No decision of this Court has sanctioned such unbridled administrative action.

Deference to agency action, even where legislative-type rules are implementing a complex statute, must yield to the clear meaning of the statute, as revealed by its language, purpose, and history. *Southeastern Community College v. Davis*, 442 U.S. 397, 411 (1979). The court below made no pretense of

attempting to consider whether the Secretary's decision was based upon "a consideration of the relevant factors." *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 416 (1971). The Secretary was allowed unfettered discretion to define "actual costs" of providing Medicare program benefits while proof of the medical value of bedside telephones was declared "appealing" but in fact ignored. Appendix at 6a. For the Secretary to be given that much discretion would cast aside entirely the doctrine of judicial review. Even where no formal rulemaking is required "the orderly function of the process of judicial review requires that the grounds upon which the administrative agency acted be clearly disclosed and adequately sustained." *SEC v. Chenery Corp.*, 318 U.S. 80, 94 (1943).

When this Court ordered a remand in *Overton Park*, it indicated that further explanation was required from the agency promulgating the rule. Only with this explanation could there be meaningful judicial review. *Overton Park*, 401 U.S. at 420. The action of the Secretary here is even more egregious: the original rule was promulgated upon no administrative record and the Provider Reimbursement Review Board accepted the Hospitals' proof of the regulation's clear inconsistency with established fact. Even in "benefits exception" cases, agency discretion is not totally without bounds. More to the point, it is improper for reviewing courts to ratify agency rulemaking when the administrative record is utterly devoid of any foundation for the agency's action. *Motor Vehicle Manufacturers*, _____ U.S. at _____, 103 S. Ct. at 2867. Moreover, the government's *post hoc* rationalizations for a regulation promulgated with neither explanation nor opportunity for comment cannot now provide the agency a platform where none existed heretofore. *Id.* _____ U.S. at _____, 103 S. Ct. at 2870. That is, not only is the regulation wrong, but further, the reviewing courts had no basis for declaring it right *or* wrong. Even if the proscription against bedside telephone reimbursement was valid when made, the *Overton Park* and *Motor Vehicle Manufacturers* decisions require the Secretary to explain that regulation when proof of its arbitrariness and inconsistency with the enabling legislation is later provided.

If a legislative rulemaking has as its essential premise a presumed fact which is proven, conclusively, to be untrue, that regulation is, *ipso facto*, arbitrary and capricious. A rulemaking must be based upon "consideration of permissible factors and be otherwise reasonable." *FCC v. National Citizens Committee for Broadcasting*, 436 U.S. 755, 793 (1978). When the court below states that the question of therapeutic value is irrelevant to its decision (Appendix at 6a-7a), it demonstrates a basic misconception of the task of both the Secretary and the reviewing courts. Where the statute provides that the full cost of regularly supplied therapeutic items will be reimbursed, for the reviewing court to declare proof of therapeutic value meaningless is the essence of arbitrariness.

The circuit court decision is similarly in conflict with *American Paper Institute v. American Electric Power Service Corp.*, _____ U.S. _____, 103 S. Ct. 1921 (1983). In discussing the more lenient arbitrary and capricious standard, Mr. Justice Marshall delineated a minimum level of judical review not even approached by the court below. That is, the duty of the courts is to "determine [1] whether the agency adequately considered the factors relevant . . . that will best serve the purposes of the statute and [2] whether the agency committed 'a clear error of judgment.' " *Id.* _____ U.S. at _____, 103 S. Ct. at 1928, *citing Overton Park*. While the Secretary provided no legislative basis for its telephone regulation, the record available to the lower courts in this case did show Conressional intent to *include* patient telephones as a reimbursable expense.

Enactment of the Medicare Act in 1965 was the culmination of extensive Congressional and Executive hearings and consolidation of numerous proposals into a single bill, H.R. 6675. One of the major proposals consolidated into H.R. 6675 during Executive Hearings of Committee on Ways and Means was H.R. 3920, which had been introduced in Congress in 1963 as President Kennedy's proposed Medicare program. During prior hearings before the Committee on Ways and Means on H.R. 3920 in November of 1963, then-Secretary Celebrezze

provided the Committee a description of covered supplies and services contemplated by the bill:

> Extra items, supplied at the request of the patient for his convenience, such as *telephones* in hospitals, would not be paid for.

Hearings Before the Committee on Ways and Means on H.R. 3920, 88th Cong., 1st and 2d Sess. 41 (1963) (emphasis added).

This description was altered when H.R. 3920 was consolidated with the other legislative proposals by the Committee on Ways and Means to produce H.R. 6675. The reference to patient telephones was deleted and in its place the Committee Report substituted the words "television rentals."

> Items supplied at the request of the patient for his convenience, *such as television rental in hospitals*, would not be paid for under the program.

House Report (Committee on Ways and Means) No. 213, 89th Cong., 1st Sess. 25 (1965) (emphasis added). Congressional substitution of television rental as a non-reimbursable service in place of the Secretary's suggestion of patient telephones strongly suggests that Congress did *not* intend patient telephones to be *per se* excluded from coverage. Congressional changes in language first proposed by the prospective administrator are significant indications of legislative intent. This is true even where there is no congressional explanation for the change. *Ashton v. Pierce*, 716 F.2d 56, 61-62 (D.C. Cir. 1983); *Symons v. Chrysler Corp. Loan Guarantee Board*, 670 F.2d 238, 242 (D.C. Cir. 1981).

The Eleventh Circuit was quite candid when it stated that the Hospitals' "appealing" arguments should be "addressed to the Secretary and not the courts." Appendix at 6a. The Hospitals presented their case to the Secretary's own Provider Reimbursement Review Board, and convinced them. Appendix at 9b-10b. There was no attempt by the Eleventh Circuit

to determine "whether [the Secretary] adequately considered the factors relevant" in deciding the bedside telephones issue. *American Paper Institute v. American Electric Power Service Corp.*, _____ U.S. _____, _____, 103 S. Ct. 1921, 1928 (1983). This total abdication of judicial review cannot be squared with even the minimal requirements of *Motor Vehicle Manufacturers, American Paper Institute* and *Overton Park*. Certiorari should be granted to correct this and to enunciate a minimum standard of review courts should apply in examining the Secretary's broad powers to set Medicare reimbursement policies.

B. The Standard of Review Applied by the Court Below Conflicts With That of the Court of Appeals for the District of Columbia Circuit.

The court below was "constrained to agree with the Seventh Circuit" that the telephone regulation at issue did not violate the arbitrary and capricious standard. Appendix at 7a. While deference is due the administrator given the task of implementing a complex statutory scheme, a reviewing court may not accept wholesale conclusions unsupported by any administrative record. The Eleventh Circuit's expansive view of the Secretary's regulatory perogatives cannot be reconciled with that of the Court of Appeals for the District of Columbia Circuit.

In *Diplomat Lakewood v. Harris*, 613 F.2d 1009 (D.C. Cir. 1979), Medicare program regulations pertaining to nursing home accounting procedures were questioned. Unlike the prohibition of reimbursement for bedside telephones, the court in *Diplomat Lakewood* had the benefit of a formal rulemaking procedure. *Id.* at 1014. The District of Columbia Circuit was not convinced by the would-be rationale for the rule espoused by the Secretary.

> But as the Supreme Court held in *SEC v. Chenery Corp.*, 318 U.S. 80, 94 . . . , the Secretary's action cannot be upheld "merely because findings might have been made and considerations disclosed which would justify [the rulemaking at issue.]" The Secretary must give "clear indication that [he] . . . has exercised the discretion with which Congress has empowered him." *Id.* at 94-95 . . .

Id. at 1018.

Here the Secretary has made no findings and has disclosed no considerations justifying the telephone regulation. The Hospitals, on the other hand, convinced the Provider Reimbursement Review Board of the rule's invalidity. Appendix at 9b-10b. The rubber-stamp standard of review of the court below cannot be squared with examination deemed appropriate by the District of Columbia Circuit *in the same Medicare context*. The proper concern of the appellate court is to ascertain "whether the agency gave 'reasonable consideration to the problem and . . . presented a rational basis for its decision.' " *Id.* at 1019. There is not a hint in the decision below that any ascertainment of the Secretary's bases for the rule was attempted. This wide divergence in the standard of judicial review deemed appropriate in the Medicare context warrants the granting of certiorari.

Legislative regulations implementing the Medicare statute determine, to a large extent, the cost and operation of the nation's entire system of health care. Both the Secretary promulgating the rules, and the courts called upon to review them, should have clear and detailed guidance from this Court. This Petition presents the Court with an ideal vehicle for providing that guidance. For that reason alone, certiorai is appropriate.

C. The Court Of Appeals, in Conflict With Cleveland Board of Eduction v. LaFleur, *Has Sanctioned an Irrebutable Conclusion of Medical Fact.*

The circuit court, in direct conflict with *Cleveland Board of Education v. LaFleur*, 414 U.S. 632 (1974), has sanctioned the Secretary's irrebutable conclusion of medical fact. The Medicare statute specifically provides that the Secretary is to promulgate rules to determine what reimbursement is due providers generally, 42 U.S.C. § 1395hh, and specifically with regard to defining "reasonable cost." 42 U.S.C. § 1395x(v)(1)(A). The rule at issue, defining whether bedside telephone service is or is not medically beneficial, has the force of law, provided "it be not in conflict with express statutory provision."

Maryland Casualty Co. v. United States, 251 U.S. 342, 349 (1920). Such legislative rulemaking must comport with the due process clause of the Fifth Amendment. Because the regulation creates a medical presumption which the Hospitals may not disprove, it cannot be distinguished from other legislative medical presumptions found constitutionally infirm by this Court. *Cleveland Board of Education v. LaFleur*, 414 U.S. 632 (1974); *see also, Vlandis v. Kline*, 412 U.S. 441 (1973) (a statutory presumption as to domicile held violative of due process). The regulation's irrebutable presumption of medical "fact," that bedside telephones are not therapeutic, should be subject to contrary proof. The Hospitals stress that the Provider Reimbursement Review Board found measurable therapeutic value. Appendix at 9b-10b. The Board, however, in denying reimbursement, declared itself to be bound by the Secretary's presumption to the contrary. This regulatory tactic, sanctioned but not discussed by the court below, cannot be squared with the holding of this Court.

> As the Court noted last Term in Vlandis v. Kline . . . "permanent irrebutable presumptions have long been disfavored under the Due Process Clauses of the Fifth and Fourteenth Amendments."

Cleveland Board of Education v. LaFleur, 414 U.S. at 644. A regulation declaring that bedside telephones cannot have medical value, no matter what the proof presented, is no less constitutionally infirm than a school board's inflexible regulation as to when a pregnant teacher is no longer fit for classroom duties. *Id.* at 644-46. The Hospitals' group appeal in this case produced a record in excess of two thousand pages in successfully arguing to the Provider Reimbursement Review Board the medical fact that telephones *are* therapeutic.

It is the position of the Secretary, sanctioned by the court below, that no matter how persuasive the proof adduced, bedside telephones are forever to be classed non-therapeutic. No explanation of or rationale for the regulation has appeared on the record in any form at any time. This Court has repeatedly held that "a statute creating a presumption which operates to

deny a fair opportunity to rebut it violates the due process clause of the Fourteenth Amendment." *Heiner v. Donnan*, 285 U.S. 312, 329 (1932). A regulation creating the same presumptions is no less infirm.

Congress delegated to the Secretary authority to decide whether bedside telephones are solely for "personal comfort" and thus the subject of reimbursement. By not including telephones as an example of a potential personal comfort item in the legislative history, Congress at least allowed providers the opportunity to prove the telephone's therapeutic benefit. Congress did not, and could not pursuant to the authorities just discussed, leave to the Secretary the power to decide a medical question without affording those affected the opportunity to rebut the finding. The Secretary, in clear conflict with *Cleveland Board of Education v. LaFleur*, has granted herself medical omniscience. Certiorari should be granted to review that action.

II. The Circuit Court's Acceptance of a Substantive Rule Promulgated Without Benefit of Hearings or Claimed Exceptions from the Administrative Procedures Act Is Inconsistent With Decisions of This Court and the Court of Appeals for the District of Columbia Circuit.

A. *Rules Promulgated With No Procedural Base Are Invalid.*

The regulation at issue was promulgated in 1966 without benefit of hearing or public comment. 31 Fed. Reg. 13534-36 (1966). The Secretary articulated no basis or rationale for the regulation, other than the statute itself. There is no explanation as to why neither health care providers nor the nation's elderly were given an opportunity to comment upon the rule. Significantly, no mention of the so-called "benefits exception" to the Administrative Procedures Act, 5 U.S.C. § 553(a)(2), was made at the time of original promulgation in 1966. Some years later the Secretary recognized that far-reaching Medicare Program regulations should be subject to pre-implementation examination, comment and criticism by providers and beneficiaries. Five years after the original, 1966, promulgation, the Secretary claimed that the section 553(a)(2) benefits

exception had applied *sub silentio*, but waived the exception's future applicability. 36 Fed. Reg. 2532 (1971). The 1971 regulation implicitly recognizes the failure of the 1965 promulgation to provide any foundation for the regulations put forth.

At this juncture, however, the Hospitals present more decisive conflict between the court below and this Court: substantive rules promulgated without benefit of formal procedure or reliance upon exception from that procedure cannot stand. "It is well-established that an agency's actions must be upheld, if at all, on the basis articulated by the agency itself." *Motor Vehicle Manufacturers Ass'n v. State Farm Mutual*, _____ U.S. _____, _____, 103 S. Ct. 2856, 2870 (1983). In this case, the circuit court's acquiescence in the Secretary's action, bottomed upon neither a formal rulemaking procedure *nor* a reliance on the benefits exception (5 U.S.C. § 553(a)(2)), is inconsistent with this Court's clearly expressed view of agency perogative. This warrants the granting of certiorari. The court below disregarded several decisions of this Court when it accepted the Secretary's after-the-fact construction of a base for the 1966 rulemaking, because "the courts may not accept appellate counsel's *post hoc* rationalizations for agency action." *Id.* Where "[t]here are no findings and no analysis . . . to justify the choice made, [and] no indication of the basis on which the Commission exercised its expert discretion[,]" the agency's action cannot be accepted. *Burlington Truck Line v. United States*, 371 U.S. 156, 167 (1962). Unless some check is placed upon the presumed agency expertise, administrative action "can become a monster which rules with no practical limits on its discretion." *Id., quoting from New York v. United States*, 342 U.S. 882 (1951). If the courts are to determine whether an agency acted within the bounds of its legislative mandate, it must "disclose the basis of its order" and "give clear indication that it has exercised the discretion with which Congress has empowered it." *Phelps Dodge v. NLRB*, 313 U.S. 177, 197 (1945). The notice and comment requirements of the Administrative Procedures Act "were designed to assure fairness and mature consideration of rules of general application." *NLRB v. Wyman-Gordon Co.*, 394 U.S. 757, 764 (1969). The telephone regulation affects thousands of hospitals and

determines millions in reimbursement. Certiorari should be granted to discover whether the Secretary has indeed acted rationally and with fairness. In this case, the Secretary, by neither claiming section 553(a)(2) exception nor explaining the telephone rule, has provided the courts no basis to examine whether the Secretary's discretion has been appropriately applied. In fact, the legislative history points toward reimbursement for patient telephones. *Ashton v. Pierce*, 716 F.2d 56 (D.C. Cir. 1983). Certiorari should be granted to allow closer examination of this wholesale sidestepping of the Administrative Procedures Act.

B. The Court Below Applied a Standard of Review Irreconcilable With That of the Court of Appeals for the District of Columbia Circuit.

When the court below allowed the Secretary to insulate her actions from judicial scrutiny, it placed itself squarely at odds with the Court of Appeals for the District of Columbia Circuit. In *National Ass'n of Home Health Agencies v. Schweiker*, 690 F.2d 932 (D.C. Cir. 1982), *cert. denied*, _____ U.S. _____, 103 S. Ct. 1193 (1983), at issue were Medicare program regulations pertaining to the assignment of reimbursement intermediaries. The rulemaking proceeded without benefit of the formal notice and comment requirements of the Administrative Procedures Act, 5 U.S.C. § 553(b) and (c). Exception was claimed pursuant to the "rules of procedure" exception, section 553(b)(A). In affirming that the district court's conclusion that the Secretary had overextended the application of the "rules of procedure" exception, the circuit court stated:

> Exceptions to the notice and comment provisions of section 553 are to be recognized "only reluctantly."... The notice and comment requirements were included in the [Administrative Procedures Act] for two main reasons. First, "to reintroduce public participation and fairness to affected parties after governmental authority has been delegated to unrepresentative agencies. And second, to "assure [ ] that the agency will have before it the facts and information relevant to a particular administrative problem, as well as suggestions for alternative solutions."

Id. at 949 (footnotes omitted). The substantive rule pertaining to bedside telephones is at least as far-reaching as the procedural matters questioned above. Exemption from the Administrative Procedures Act "cannot apply . . . where the agency action trenches on substantive rights and interests." *Id., quoting from Batterton v. Marshall*, 648 F.2d 694, 708 (D.C. Cir. 1980). While in an earlier case the District of Columbia Circuit had sanctioned the use of the benefits exception in a Medicare matter,[3] the Hospitals contend that the views expersed in *National Ass'n of Home Health Agencies* cannot be reconciled with the court below. Other District of Columbia decisions would limit the unwarranted use of section 553 exceptions:

> Congress was alert to the possibility that these exceptions might . . . defeat the section's purpose. Thus, the legislative history of the section is scattered with warnings that various of the exceptions are not to be used to excape the requirements of section 553.

American Bus Association v. United States, 627 F.2d 525, 528 (D.C. Cir. 1980). "The critical question is whether the agency action jeopardizes the rights and interest of parties, for if it does, it must be subject to public comment prior to taking effect." *Batterton v. Marshall*, 648 F.2d 694, 708 (D.C. Cir. 1980) (footnote omitted). This conflict will only be resolved through the granting of certioari.

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[3] *Humana of South Carolina v. Califano*, 590 F.2d 1070 (D.C. Cir. 1980).

CONCLUSION

For these reasons, a writ of certiorari should issue to review the judgment and opinion of the Court of Appeals for the Eleventh Circuit.

Respectfully submitted,

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November 9, 1983

UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 81-6230

MEMORIAL HOSPITAL, ET AL.,
Plaintiffs-Appellants,
Cross-Appellees,

v.

MARGARET M. HECKLER, SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
Defendent-Appellant,
Cross-Appallant

Argued November 17, 1982 Decided June 6, 1983

Before Roney and Johnson, Circuit Judges, and Dyer, Senior Circuit Judge.

RONEY, Circuit Judge:

In this case we make two significant decisions. First, we hold that hospitals are not entitled to Medicare reimbursement for telephone services provided to patients, since they are excluded as "personal comfort items." On this decision we are in accord with the only other court of appeals case on point. *Saint Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F.2d 1337 (7th Cir. 1983).

Second, we hold that hospitals may not charge the federal Medicare program for the free care provided to patients as a condition for receiving Hill-Burton construction subsidies. This brings the Eleventh Circuit in line with the other four circuits that have considered the issue. *See Iredell Memorial Hospital v. Schweiker*, 699 F.2d 196 (4th Cir. 1983); *Johnson County Memorial Hospital v. Schweiker*, 698 F.2d 1347 (7th Cir. 1983); *Saint Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F.2d 1337 (7th Cir. 1983); *Metropolitan Medical Center v. Harris*, 693 F.2d 775 (8th Cir. 1982); *Harper-Grace Hospitals v. Schweiker*, 691 F.2d 808 (6th Cir. 1982).

Plaintiffs, sixty-one Florida general acute care hospitals and one hospital in the District of Columbia, are qualified providers of medical services under the Medicare provisions of the Social Security Act, 42 U.S.C. § 1395 *et seq.* They are entitled to be reimbursed for reasonable costs incurred in the provision of necessary health services to Medicare beneficiaries. 42 U.S.C.A. § 1395x(v)(1)(A). As Medicare providers, the hospitals receive periodic reimbursements from a fiscal intermediary of the Department of Health and Human Services. 42 U.S.C.A. § 1395g, 1395h. Providers file cost reports with the intermediary at the end of each fiscal year. 42 U.S.C.A. § 1395g; 42 C.F.R. § 405.453(f) (1981). The intermediary may then retroactively adjust the payments made during the previous year.

In this case, the intermediary denied reimbursement for patient telephone costs and Hill-Burton expenses incurred in various cost reporting periods ending in 1976 and 1977. The hospitals appealed the intermediary's action to the Provider Reimbursement Review Board (PRRB) pursuant to 42 U.S.C.A. §1395*oo*(a). The PRRB affirmed the intermediary's action on both counts, holding that it had no jurisdiction to review the intermediary's decision on the patient telephone expense issue. The PRRB decision was not affirmed, reversed, or modified by the Secretary within sixty days of issuance, and therefore became final. 42 U.S.C.A. § 1395*oo*(f)(1).[1] The hospitals appealed to the district court.

The hospitals appeal from the district court's decision which (1) rejected the hospitals' claim for reimbursement of patient telephone costs, and (2) upheld as reasonable the accounting system used in excluding patient telephone costs. The Secretary of the Department of Health and Human Services cross-appeals from the district court's decision which held that

[1] 42 U.S.C.A. § 1395*oo*(f)(1), as amended in 1980, provides:
A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which such determination is rendered . . . Such action shall be brought in the district court of the United States for the judicial district in which the provider is located or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5, notwithstanding any other provisions in section 405 of this title.

Hill-Burton costs are reimbursable under the Medicare program. We affirm on the appeal, and reverse on the cross-appeal.

I.

PATIENT TELEPHONE COSTS

A. *Jurisdiction*

The Secretary contends there can be neither administrative nor judicial review of the intermediary's denial of reimbursement for patient telephone expenses. This jurisdictional argument is based upon 42 U.S.C.A. § 1395*oo*(g), which provides:

> The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section.

Patient telephone costs are not specifically mentioned in section 1395y, but section 1395y(a) provides:

> no payment may be made under part A or part B of this subchapter for any expenses incurred for items or services – . . . (6) which constitute personal comfort items.

A Medicare regulation issued by the Secretary cites patient telephone service as an example of a "personal comfort item":

> Notwithstanding any other provisions of this Part 405, no payment may be made for any expenses incurred for the following items or services:
>
> . . . .
>
> (j) Personal comfort items and services (for example a television set, or telephone service, etc.)
>
> 42 C.F.R. § 405.310(j).

Following the Secretary's regulation, the intermediary rejected the hospitals' claim for patient telephone expenses as a "personal comfort item" excluded under section 1395y. The PRRB and the district court concluded that they lacked

jurisdiction to review the intermediary's finding because section 1395oo (g) precludes PRRB or judicial review of an intermediary's decision to deny reimbursement for items or services "listed in section 1395y."

In essence, the issue here does not involve just an intermediary finding that no payment may be made. Rather, it concerns the validity of the regulation itself. The intermediary merely followed the Secretary's regulation. We hold that section 1395oo(g) does not preclude judicial review of the Secretary's regulation defining patient telephones as "personal comfort items." Section 1395oo(g) does not preclude judicial review of the Secretary's regulations. Although one of the categories "listed in" section 1395y is "personal comfort items," no specific personal comfort item is identified or described in the statute. The Secretary's determination that patient telephones are personal comfort items is reviewable. *Saint Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F.2d 1337, 1345-46 (7th Cir. 1983). To expand the non-reviewability of intermediary decisions to include policy decisions of the Secretary would not merely insulate from judicial scrutiny the finding of an intermediary. It would give the Secretary virtually unbridled discretion to prevent reimbursement through regulations. Such a result would run contrary to the presumption favoring judicial review. *See Abbott Laboratories v. Gardner*, 387 U.S. 135, 141, 87 S. Ct. 1507, 1511, 18 L.Ed.2d 681 (1967) ("[O]nly upon a showing of 'clear and convincing evidence' of a contrary legislative intent should the courts restrict access to judicial review."); *Deering Milliken, Inc. v. Occupational Safety & Health Review Comm.*, 630 F.2d 1094, 1099 (5th Cir. 1980).

B. *Validity of the Regulation*

In *Presbyterian Hospital of Dallas v. Harris*, 638 F.2d 1381 (5th Cir. 1981), *cert. denied*, 454 U.S. 940, 102 S. Ct. 476, 70 L.Ed.2d 248 (1981), the Fifth Circuit held the Government was not constitutionally required to fund a patient's access to television and telephone service. It did not decide whether the

Secretary had authority under the statute to deny reimbursement for patient telephones through regulation. The hospital did not "seriously argue" that regulation 405.310(j) was beyond the authority of the Secretary. 638 F.2d at 1384.

The question in this case is whether the Secretary's decision, to reimburse providers for the cost of telephones used in emergency communications systems and to deny reimbursement for telephones used by patients to call friends and relatives, is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C.A. § 706(2)(A). The Secretary is authorized to prescribe regulations necessary to carry out the Medicare program, 42 U.S.C.A. § 1395hh, and to determine Medicare reimbursement questions in accordance with those regulations. 42 U.S.C.A. § 1395ff(a).

The hospitals argue that the Secretary's discretion in defining "personal comfort items" is limited by the legislative history of section 1395y(a)(6), which states:

> [S]uch potential personal comfort items and services as massages and heat lamp treatments would only be covered where they contribute meaningfully to the treatment of an illness or injury. . . .

S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U. S. Code Cong. & Ad. News 1943, 1989. The hospitals, contending that this indicates a Congressional intent to provide reimbursement for any potential personal comfort items that have therapeutic value, introduced extensive evidence to show that inroom patient telephones which provide access to friends and relatives aid in the healing process. Although the hospitals' arguments are appealing, it appears to us that under the precedents by which we are controlled, they should be addressed to the Secretary rather than to the courts. The question is not whether telephones have therapeutic value, but whether the costs of patient telephones should be reimbursed by the Medicare program.

In determining the validity of the Secretary's regulation, we are required to grant considerable deference to the agency's determination. The agency, not the courts, bears the ultimate

fiscal responsibility to Congress. The agency regulations prescribed by the Secretary take on "legislative effect." *Schweiker v. Gray Panthers*, 453 U.S. 34, 44, 101 S.Ct. 2633, 2640, 69 L.Ed.2d 460 (1981). "Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term," and a reviewing court may not reverse the agency "simply because it would have interpreted the statute in a different manner." *Batterton v. Francis*, 432 U.S. 416, 425, 97 S. Ct. 2399, 2405, 53 L.Ed.2d 448 (1977). *See Health Care Service Corp. v. Califano*, 601 F.2d 934, 935-36 (7th Cir. 1979) (interpretation of complex statute such as the Medicare Act, by the officer charged with administering it, is entitled to considerable deference, and not to be rejected by a court because another interpretation may also be reasonable); *Homan & Crimen, Inc. v. Harris*, 626 F.2d 1201, 1204 (5th Cir. 1980).

We are constrained to agree with the Seventh Circuit that the Secretary's determination is not arbitrary, capricious or an abuse of discretion, is consistent with the Medicare Act and regulations, and is therefore valid and enforceable. *Saint Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F.2d 1337, 1346-47 (7th Cir. 1983).

C. *Method of Cost Allocation*

In excluding patient telephones from Medicare reimbursement, the Secretary employs the "average costing" method, attributing to each telephone in the hospital its proportionate share of total hospital telephone expenses (telephone bills, switchboards, operators, etc.), and then excluding from reimbursement the expenses of all phones assigned to patient use. The PRRB and the district court upheld this method for determining the amount of excluded patient telephone costs, relying

on 42 C.F.R. § 405.451(b)(1)[2] and section 2106.1[3] of the Provider Reimbursement Manual. This accounting method was upheld in *Saint Mary of Nazareth v. Department of Health and Human Services*, 698 F.2d 1337, 1347 (7th Cir. 1983). The hospitals contend that only the marginal costs of patient phones should be excluded: "[T]he hospitals should be reimbursed, fully, for what their telephone system would have cost, had there been no installation of patient telephones." Although the accounting procedures suggested by the hospital might also be reasonable, the method used by the Secretary is consistent with the Medicare Act and regulations, cannot be regarded as arbitrary, capricious or an abuse of discretion, and therefore must be upheld.

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[2] 42 C.F.R. § 405.451(b)(1) provides in pertinent part:

> Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this subpart take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program.

[3] Section 2106.1 of the Manual provides in pertinent part:

> The *full* costs of items or services such as telephone, television, and radio which are located in patient accommodations and which are furnished solely for the personal comfort of the patients (full costs include costs both directly associated with personal comfort items or services plus an appropriate share of indirect costs) are not includable in allowable costs of providers under the Medicare program. To illustrate the full costs of telephones used solely for the personal comfort of patients include not only costs directly associated with these telephones, such as the rates billed by the public utility, but also an appropriate share of indirect telephone costs, e.g., operators' salaries, equipment, space-related costs of switchboard and other equipment etc., as well as any other overhead that may be applicable thereto (emphasis in original).

II.

HILL-BURTON COSTS

The Secretary appeals from the district court decision which held that the hospitals are entitled to Medicare reimbursement for costs incurred in providing the free care to indigents required by the Hill-Burton Act, 42 U.S.C.A. § 291 *et seq.* The district court relied upon *Presbyterian Hospital of Dallas v. Harris*, 638 F.2d 1381 (5th Cir.), *cert. denied*, 454 U.S. 940, 102 S. Ct. 476, 70 L.Ed.2d 248 (1981), which allowed Medicare reimbursement for Hill-Burton expenses. In August, 1982, however, after *Presbyterian Hospital* was decided, Congress passed the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248, 1982 U.S. Code Cong. & Ad. News (97 Stat.) 1. Section 106 of this Act clearly disallows reimbursement, contrary to the *Presbyterian Hospital* holding.

The Hill-Burton Act, 42 U.S.C.A. § 291 *et seq.*, provides federal funds for the construction and modernization of hospitals. In order to receive Hill-Burton funds, hospitals must provide a reasonable amount of free care to indigents. 42 U.S.C.A. § 291c(e)(2). A hospital may satisfy this obligation to provide uncompensated care to indigents for a 20-year period in one of two ways: (1) it may budget for free care to indigents at a level not less than the lesser of 3 percent of its operating costs or 10 percent of all federal assistance received under the Hill-Burton Act, or (2) it may certify that it will follow an "open door" policy, providing care to all indigents appearing at the hospital in need of care. 42 C.F.R. § 53.111(d).

Section 106 of the Tax Equity and Fiscal Reform Act amends the Medicare Act to provide: (1) that the Secretary's Medicare regulations shall provide that a hospital's costs in providing Hill-Burton free care to indigents are not reimbursable as reasonable costs, and (2) that the amendment shall be effective with respect to any Hill-Burton costs, except for those

previously allowed by a final Court of Appeals judgment.[4] The Secretary has promulgated the regulations mandated by section 106.[5] The legislative history accompanying section 106 states: "The provision is intended to clarify that Hill-Burton free care costs have never been, and are not, allowable for

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[4] The amendment to 42 U.S.C.A. §1395x(v)(1), provides:

Section 106. (a) Section 1861(v)(1) of the Social Security Act is amended by adding at the end the following new subparagraph:

(M) Such regulations shall provide that costs respecting care provided by a provider of services, pursuant to an assurance under Title VI or XVI of the Public Health Service Act that the provider will make available a reasonable volume of services to persons unable to pay therefore, shall not be allowable as reasonable costs."

(b) The amendment made by subsection (a) shall be effective with respect to any costs incurred under Title XVIII of the Social Security Act, except that it shall not apply to costs which have been allowed prior to the date of the enactment of this Act pursuant to the final court order affirmed by a United States Court of Appeals.

[5] 47 Fed.Reg. 43658 (Oct. 1, 1982), to be codified at 42 C.F.R. § 405.420, provides:

(b) *Definitions.*–

• • • •

(2) *Charity allowances.* Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. Cost of free care (uncompensated services) furnished under a Hill-Burton obligation are considered as charity allowances.

• • • •

(g) *Charity allowances.* Charity allowances have no relationship to beneficiaries of the health insurance program and are not allowable costs. These charity allowances include the costs of uncompensated services furnished under a Hill-Burton obligation. (Note: In accordance with Sec. 106(b) of Pub. L. 97-248 (enacted September 3, 1982), this sentence is effective with respect to any costs incurred under title XVIII of the Social Security Act, except that it does not apply to costs which have been allowed prior to September 3, 1982, pursuant to a final court order affirmed by a United States Court of Appeals). The cost to the provider of employee fringe-benefit programs is an allowable element of reimbursement.

Medicare reimbursement purposes."[6] The amendment thus expressly removes the costs associated with a hospital's Hill-Burton obligation from the "reasonable costs" reimbursable under the Medicare program. The hospitals launch a series of attacks on the control of section 106 on the decision in this case.

First, we consider whether the court should apply section 106, which was not yet in effect at the time this litigation was instigated. We agree with the Sixth Circuit that section 106 applied to appeals that were pending when it was enacted. *Harper-Grace Hospitals v. Schweiker*, 691 F.2d 808, 811 (6th Cir. 1982). A court should apply the law in effect at the time it renders its decision, unless doing so would result in manifest injustice or there is statutory direction or legislative history to the contrary. *Bradley v. Richmond School Board*, 416 U.S. 696, 711, 94 S.Ct. 2006, 2016, 40 L.Ed.2d 476 (1974); *United States v. Schooner Peggy*, 5 U.S. (1 Cranch) 102, 109 (1801) ("if subsequent to the judgment and before the decision of the appellate court a law intervenes and positively changes the rule which governs, the law must be obeyed . . . ."). Therefore, as to this appeal, *Presbyterian Hospital of Dallas v. Schweiker*, 638 F.2d 1381 (5th. Cir.), *cert. denied*, 454 U.S. 940, 102 S.Ct. 476, 70 L.Ed.2d 248 (1981), which allowed Medicare reimbursement for Hill-Burton costs, is not controlling.

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[6] The legislative history accompanying section 106 provide:

House committee provision
The House committee provision requires the Secretary to provide, by regulation, that the costs incurred by a hospital or skilled nursing facility in complying with its free care obligation under the Hill-Burton Act would not be considered reasonable costs for purposes of Medicare reimbursement. The provision is effective for costs incurred on or after date of enactment.

Conference Agreement
The conference agreement includes the House Committee provisions. The provision is intended to clarify that Hill-Burton free care costs have never been, and are not, allowable for Medicare reimbursement purposes. The provision, therefore, applies to all, such costs that have been, or will be incurred except those recognized by the final judgment of a U. S. Court of Appeals entered into prior to enactment.

H.R. Rep. No. 760, 97 Cong., 2d Sess. 431, *reprinted in* 1982 U.S. Code Cong. & Ad. News, (97 Stat.) 412, 433.

Second, the hospitals argue that application of section 106 to their Hill-Burton claim would result in an unconstitutional taking of their property without just compensation in violation of the fifth amendment, because it would abrogate a vested contractual right to Medicare reimbursement. Upon joining the Medicare program, however, the hospitals received a statutory entitlement, not a contractual right. Although the hospitals entered into an "agreement" with the Secretary that they would abide by the rules of the Medicare program, that agreement did not obligate the Secretary to provide reimbursement for any particular expenses such as Hill-Burton costs. This constitutional challenge to section 106 was rejected in *Harper-Grace Hospitals v. Schweiker*, ___F.2d___, [No. 81-1305, 6th Cir., March 23, 1983] (6th Cir. 1983) (denial of rehearing), and *Saint Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F.2d 1337, 1343-45 (7th Cir. 1983). *See Arlington Hospital v. Schweiker*, 547 F. Supp. 670, 674-75 (E.D. Va. 1982). Courts have upheld retroactive adjustments in the Medicare reimbursement system. *See, e.g., Springdale Convalescent Center v. Mathews*, 545 F.2d 943, 955-57 (5th Cir. 1977); *Adams Nursing Home v. Mathews*, 548 F.2d 1077, 1081 (1st Cir. 1977) ("the expectations of those who enter a regulated field are diluted by the knowledge that occasional changes will be made to better carry out regulatory purposes"). This case is not similar to *Lynch v. United States*, 292 U.S. 571, 54 S. Ct. 840, 78 L. Ed. 1434 (1934), where a legislative enactment repudiated and abrogated insurance contracts of the United States.

Third, the hospitals, relying upon *United States v. Klein*, 80 U.S. (13 Wall.) 128, 20 L.Ed. 519 (1872), argue that Congress may not "prescribe rules of decision" in matters that are in litigation, particularly where a lower court judgment has been entered against the Government. Although Klein contains language questioning the power of Congress to "prescribe a rule of decision to the Judicial Department of the Government in cases pending before it," 80 U.S. at 146, its holding invalidated legislation which both dictated to the judiciary how to resolve factual questions and interfered with the President's pardon power. In *American International Group, Inc. v. Islamic Republic of Iran*, 657 F.2d 430, 442 (D.C. Cir. 1981),

the court stated that *Klein* should not be read as casting doubt on the principle "that the courts are obligated to apply law (otherwise valid) as they find it at the time of final judgment, including, when a case is on review, the time of appellate judgment." Until appellate rights are exhausted, even an otherwise valid judgment may be negated by supervening legislation. *See, e.g., 149 Madison Ave. Corp. v. Asselta*, 331 U.S. 795, 67 S.Ct. 1726, 91 L.Ed. 1822 (1947), *modifying* 331 U.S. 199, 67 S.Ct. 1178, 91 L.Ed. 1432 (1947), (Supreme Court modified its own judgment to allow a district court to consider a defense created by Congress after the Supreme Court's judgment, but during the time for rehearing); *Electronic Data Systems v. Social Security Organization*, 651 F.2d 1007, 1011 (5th Cir. 1981); *De Rodulfa v. United States*, 461 F.2d 1240, 1250 (D.C. Cir.), *cert. denied*, 409 U.S. 949, 93 S.Ct. 270, 34 L.Ed. 2d 220 (1972). Although there may be constitutional problems with legislation purporting to disturb final judgments that have conferred vested rights, the district court judgment in this case, still pending on appeal, was not final. *See De Rodulfa v. United States*, 461 F.2d at 1252-53. Congress specifically provided in section 106 that Hill-Burton costs previously allowed by a final Court of Appeals judgment would not be affected.

Fourth, although the hospitals argue that denying Medicare reimbursement for Hill-Burton costs will shift those costs to non-Medicare patients in violation of 42 U.S.C.A. § 1395x(v)(1)(A) (Medicare regulations must provide that costs of covered services to Medicare patients will not be borne by non-Medicare patients), they fail to recognize that the condition for receiving Hill-Burton funds is the extension of free care to indigents, 42 U.S.C.A. § 291c(e)(2). Neither are the hospitals forced to operate at a loss, resulting in a "taking" of their property. The Government has not confiscated property because the hospitals had no enforceable property right to reimbursement. *See generally Penn Central Transportation Co. v. New York City*, 438 U.S. 104, 124, 98 S.Ct. 2646, 2659, 57 L.Ed. 2d 631 (1978).

There is no merit to the hospitals' contention that Congress violated the equal protection clause by irrationally discriminating between Hill-Burton claims already allowed

pursuant to a final court of appeals judgment, as in *Presbyterian Hospital of Dallas v. Schweiker*, 638 F.2d 1381 (5th Cir.), *cert. denied*, 454 U.S. 940, 102 S.Ct. 476, 70 L.Ed. 2d 248 (1981), and those claims still in litigation.

Four other circuits have reached the same conclusion that Hill-Burton costs are not reimbursable under the Medicare program. *See Iredell Memorial Hospital v. Schweiker*, 699 F.2d 196 (4th Cir. 1983); *Saint Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F.2d 1337 (7th Cir. 1983); *Metropolitan Medical Center v. Harris*, 693 F.2d 775 (8th Cir. 1982); *Harper-Grace Hospitals v. Schweiker*, 691 F.2d 808 (6th Cir. 1982). In *Saint Mary of Nazareth*, the Seventh Circuit found section 106 to be constitutionally sound, noting the hospitals' lack of a "vested right" to reimbursement and the strong public interest in the clarification of congressional acts. It also stated that section 106 was supported by public policy, "because to allow hospitals to use one federal program to fund their obligations under another in an attempt to 'charge back' their excess costs to the government runs contrary to a reasonable reading of the two Acts." 698 F.2d at 1345. The Sixth Circuit, in *Harper-Grace Hospitals v. Schweiker*, 691 F.2d 808 (6th Cir. 1982), applied section 106, relying on the general rule that courts must apply the law in effect at the time it renders its decision. The court did not address the constitutionality of section 106 in its original opinion, but stated in its denial of rehearing that section 106 was not an unconstitutional "taking" of property. *Harper-Grace Hospitals v. Schweiker* [No. 81-1305, March 23, 1983]. In *Metropolitan Medical Center v. Harris*, 693 F.2d 775 (8th Cir. 1982), the court declined to rely on section 106, resting its decision on the legislative history behind the Medicare and Hill-Burton Acts. "The test of the [Hill-Burton] Act, its implementing regulations, its legislative history, and the case law construing it all show that Medicare reimbursement for free care costs is inconsistent with the Hill-Burton Act." *Metropolitan Medical Center*, 693 F.2d at 782.

AFFIRMED ON APPEAL, REVERSED ON CROSS-APPEAL.

IN THE

UNITED STATES DISTRICT COURT

FOR THE MIDDLE DISTRICT OF FLORIDA

ORLANDO DIVISION

MEMORIAL HOSPITAL, et al.,

Plaintiffs,

v.

RICHARD S. SCHWEIKER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Defendant.

Civil Action No. 80-67-Orl.-Civ.-Y

Filed: October 20, 1981

HOFFMAN, District Judge

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* The Honorable Walter E. Hoffman, United States District Court for the Eastern District of Virginia, sitting by designation.

OPINION

This case arises from an action brought by sixty-two plaintiff hospitals seeking review of a final decision by the Secretary of Health and Human Services (hereinafter the Secretary) which denied Medicare reimbursement for certain expenses incurred by the plaintiffs in 1976 and 1977. In particular, the plaintiffs challenge the disallowance of expenses incurred in the provision of: (1) free medical care to indigents, as required by the Hill-Burton Act, 42 U.S.C. § 291, et seq. (1976), and (2) in-room patient telephones. This court finds that: (1) plaintiffs' Hill-Burton expenses are reimbursable, and (2) it lacks jurisdiction to determine plaintiffs' patient telephone claim. The case is remanded to the Secretary for disposition in accordance with this opinion.

I.

FACTS

Plaintiffs are sixty-one Florida general acute care hospitals and one hospital in the District of Columbia. Plaintiffs are qualified providers of medical services under Part A of the Medicare provisions of the Social Security Act, 42 U.S.C. § 1395 *et seq.* (1976), and are entitled to be reimbursed for reasonable costs [1] incurred in the provision of necessary health

[1] Reasonable costs are defined in 42 U.S.C. §1395x(v)(1)(A) (1976) which provides in pertinent part:

The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs . . . . Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs provides to be either inadequate or excessive.

services to Medicare beneficiaries. 42 U.S.C. §§1395f(b), 1395x(v)(1)(A)(1976). As Medicare providers, plaintiffs are entitled to periodic reimbursements from a fiscal intermediary of the Department of Health and Human Services. 42 U.S.C. §§ 1395g, 1395h (1976). At the conclusion of each fiscal year Medicare providers file cost reports with the intermediary. 42 U.S.C. § 1395g; 42 C.F.R. §405.453(f) (1979). The intermediary may then retroactively adjust the payments it has made during the previous year. *Id.*

The fiscal intermediary (the Intermediary) for all but one of the plaintiffs is the Blue Cross Association, through its local subsidiaries in Florida and Washington, D.C.[2] The Intermediary adjusted plaintiffs' cost reports and denied reimbursement for plaintiffs' expenses incurred for Hill-Burton and patient telephone costs in various cost reporting periods ending in 1976 and 1977. The plaintiffs appealed the Intermediary's decision to the Provider Reimbursement Review Board of the Department of Health and Human Services (PRRB), pursuant to 42 U.S.C. §1395*oo*(a) (1976). The PRRB affirmed the Intermediary's adjustment to disallow plaintiffs' Hill-Burton and patient telephone expenses. The PRRB found it did not have jurisdiction to decide the patient telephone expenses issue.[3] Pursuant to 42 U.S.C. § 1395*oo*(f) (1976), the PRRB's decision became the final decision of the Secretary when the Administrator of the Health Care Financing Administration (hereinafter HCFA), acting on behalf of the Secretary, failed to affirm, reverse, or modify the PRRB's decision within sixty days of issuance. The plaintiffs then sought judicial review of this decision pursuant to 42 U.S.C. § 1395*oo*(f).

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[2] Mutual of Omaha is the intermediary for Miami-Dade General Hospital.

[3] The PRRB did reach the merits of the patient telephone issue and agreed with plaintiffs that this should be a covered item for reimbursement purposes, but stated it was "locked into" 42 C.F.R. §405.310(j) which prohibits reimbursement for personal comfort items such as patient telephones. The PRRB stated that it, therefore, did not have the authority to rule on this coverage issue. *Florida Hospital Group Appeal v. Blue Cross Association/Various Blue Cross Plans*, Provider Reimbursement Review Board Decision No. 79-D91 at 66 (Dec. 17, 1979) [hereinafter cited as PRRB Decision No.

The Fifth Circuit's recent decision in *Presbyterian Hospital of Dallas v. Harris*, 638 F.2d 1381 (5th Cir. 1981), *petition for cert. filed*, 49 U.S.L.W. 2616 (U.S. Aug. 10, 1981) (No. 81-264), addressed the two issues central to this litigation. The Fifth Circuit decided that Hill-Burton expenses were reimbursable as a matter of law and that decision is controlling here. The Fifth Circuit also decided that patient telephone and television expenses were not reimbursable after rejecting First Amendment arguments that were not raised in this case. This court finds that it lacks jurisdiction to determine plaintiffs' patient telephone claim based on the plain language of the applicable statutes and regulations.

II.

HILL-BURTON COSTS

The Hill-Burton Act, 42 U.S.C. § 291, *et seq.* (1976), provides outright grants or interest subsidies on construction loans to hospitals for hospital construction or modernization. Hospitals must provide a specified amount of free medical care to indigents to receive this financial assistance. This *quid-pro-quo* arrangement to provide uncompensated care to indigents for a 20-year period can be satisfied in one of two ways (1) the hospitals may budget for free care to indigents at a level not less than the lesser of 3 percent of its operating costs or 10 percent of all federal assistance received under the Hill-Burton Act or (2) the hospitals may certify that they will follow an "open door" policy and not exclude any person from admission on the ground that such person is unable to pay for needed services. 42 C.F.R. §53.111(d) (1979).

The Intermediary refused to reimburse plaintiffs' costs for providing the Hill-Burton care to indigents on the grounds such costs represented charity care pursuant to 42 C.F.R. §405.420(c).[4] Plaintiffs then sought review of the Intermediary's decision before the PRRB.

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[4] 42 C.F.R. § 405.420(c) provides that "[bad debts, charity and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing services. Such costs have already been incurred in the production of the services."] 42 C.F.R. §405.420(b)(2) defines charity allowances as "reductions in charges made by the provider of services because of the indigence or medical indigence of the patient."

Plaintiffs argued before the PRRB that the cost of providing free medical care to indigents constituted a reasonable and necessary cost or providing care to their general patient population in their Hill-Burton financed facilities. Plaintiffs contended that such care was not a voluntary and charitable act, but mandated by their contractual Hill-Burton obligations. Plaintiffs further contended that such costs were similar to interest and other financing costs and were reasonable costs that should be reimbused by the Medicare program. The PRRB rejected plaintiffs' arguments and affirmed the Intermediary's decision based on the 42 C.F.R. §405.420(c) interpretation that precludes reimbursement for charity allowances. PRRB Decision No. 79-D91.

The Fifth Circuit's decision in *Presbyterian Hospital, supra,* is dispositive on the Hill-Burton costs reimbursement issue in this case. The Fifth Circuit found that Hill-Burton costs of providing free care to indigents pursuant to the terms of a Hill-Burton interest subsidy were reimbursable under the medicare program. The court stated:

> We note that both the statute and the regulations provide for reimbursement for indirect as well as direct costs. 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 405.451(c)(3) (1979). Indeed, the regulations allow reimbursement for a number of specific indirect costs, including depreciation, interest, some types of bad debts, research costs, and even a return on the equity capital of proprietary owners. See 42 C.F.R. § 405.401 *et seq.* (1979). In particular, an interest payment actually made by the Hospital to a lender of funds is clearly reimbursable, 42 C.F.R. § 405.419(b) (1979), and the Hospital was in fact reimbursed for that portion of the interest on its outstanding loans which was paid by the Hospital rather than by the government pursuant to the Hill-Burton Act. Although free care expenses are not 'interest' within the meaning of the regulations, *see id.*, we are unable to distinguish such expenses in principle from interest and other indirect costs. It is undisputed that the Hospital was legally obligated to make such expenses, and it is also undisputed that the expenses indirectly benefited Medicare patients by

> qualifying the Hospital for interest subsidies on construction and modernization projects. The fact that such expenses also benefited indigent persons who were not Medicare beneficiaries is irrelevant to the determinative issue: whether the expenses were a reasonable cost incurred in the provision of services to Medicare patients. We conclude, therefore, that the free care expenses incurred by the Hospital in connection with its obligations under the Hill-Burton Act were reasonable costs of providing care to all of its patients, including Medicare patients, and are consequently reimbursable to the extent that this indirect cost benefited Medicare patients.

638 F.2d at 1387 (footnote omitted)[5]; *see also Rapides General Hospital v. Matthews*, 435 F. Supp. 384 (W.D. La. 1977), *vacated and remanded on other grounds*, No. 77-3124 (5th Cir. Oct. 23, 1978) (unpublished order).

Although most of the plaintiffs in this case received Hill-Burton grants, and not interest subsidies as in *Presbyterian Hospital*, the difference is not relevant for disposition of the cross-motions for summary judgment. This court is bound by the Fifth Circuit's decision that Hill-Burton costs are reimbursable by the Medicare program. Therefore, plaintiffs are entitled to judgment on the Hill-Burton issue as a matter of law.

III.

PATIENT TELEPHONE COSTS

The Fifth Circuit's decision in *Presbyterian Hospital* is not dispositive of the patient telephone issue. The *Presbyterian Hospital* court dealt primarily with the issue of whether the government was "constitutionally required to fund a patient's access to television and telephone service." *Presbyterian Hospital*, 638 F.2d at 1385. The decision took a limited approach to the patient telephone issue:

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[5] The *Presbyterian Hospital* opinion reported at 638 F.2d 1381, 1387 added the phrase "to the extent that this indirect cost benefited Medicare patients" to the last sentence of the cited passage as was originally reported in the advance sheets. This phrase does not alter the Fifth Circuit's holding on the Hill-Burton costs issue.

> The Social Security Act specifically excludes "personal comfort items" from Medicare coverage. 42 U.S.C. § 1395y(a)(6)(1976). Interpreting this provision, regulations of the Department of Health and Human Services list "a television set" and "telephone service" as examples of personal comfort items. 42 C.F.R. § 405.310(j) (1979). The Hospital does not seriously argue that this interpretation is beyond the authority of the Secretary.

638 F. 2d at 1384 (footnote omitted). However, plaintiffs in the instant case do challenge the Secretary's authority to deny reimbursement for the costs or providing in-room patient telephones through 42 C.F.R. §405.310(j) and hence, the patient telephone issue must be analyzed in a different manner than the *Presbyterian Hospital* approach.

A. *Jurisdiction*

The PRRB decided that it did not have jurisdiction to review the Intermediary's disallowance of plaintiffs' claim for reimbursement of patient telephone costs. The Secretary argues that this court similarly lacks subject matter jursidiction to review the Intermediary's decision. The Secretary attempts to limit this court's jurisdiction through his interpretation of 42 U.S.C. § 1395*oo*(g) which provides:

> The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) [6] of this section.

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[6] 42 U.S.C. §1395*oo*(f)(1) provides:

A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5, notwithstanding any other provisions in section 405 of this title.

Patient telephone costs are not "listed" in 42 U.S.C. § 1395y; however, 42 U.S.C. § 1395y(a)(6) lists "personal comfort items" as a category of excluded services for Medicare reimbursement.[7] Medicare regulations issued pursuant to 42 U.S.C. § 1395hh [8] define patient telephones as an example of an excluded service. 42 C.F.R. § 405.310(j).[9]

This jurisdictional argument precludes the PRRB, or any court, from reviewing the Intermediary's finding that no payment may be made for plaintiffs' telephone costs. The PRRB clearly held that patient telephones have therapeutic value and should be a covered service for reimbursement purposes, but

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[7] 42 U.S.C. §1395y(a)(6) provides:

Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B of this subchapter for any expenses incurred for items or services– . . . .

(6) which constitute personal comfort items.

[8] 42 U.S.C. § 1395hh provides:

The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term 'regulations' means, unless the context requires, regulations prescribed by the Secretary.

[9] 42 C.F.R. §405.310(j) provides:

Notwithstanding any other provisions of this Part 405, no payment may be made for any expenses incurred for the following items or services:

. . . .

(j) Personal comfort items and services (for example a television set, or telephone service, etc.).

correctly decided that it lacked jurisdiction to decide this coverage issue.[10] Congress has the power to limit the jurisdiction of the PRRB and the district courts and has expressly limited jurisdiction on this issue.[11] Therefore, this court finds that it does not have jurisdiction to review the Intermediary's finding that plaintiffs' patient telephone costs are not reimbursable based on the unambiguous language of § 1395*oo*(g). If not for this section, the court might very possibly be required to respect the PRRB finding that patient telephones should

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[10] Plaintiffs' attempt to bolster their argument by noting that since the time of the administrative hearing in this case, the PRRB and the Secretary, acting through the HCFA, have recognized that patient telephone costs incurred with respect to the hospital usage of a patient telephone (as opposed to the patient usage) in the context of a Centrex telephone system are reimbursable. *See Bethesda Hospital v. Blue Cross Association*, PRRB Decision No. 80-D78 (Nov. 20, 1980). However, the reimbursable portion of the Centrex telephone system dealt with the intercom function of the patient telephones which was held to be related to patient care and reimbursable. These costs could be segregated out by the phone company and, hence, the PRRB held that these costs were reimbursable. Other telephone costs pertaining to personal comfort of patients were not considered reimbursable costs. Therefore, the *Bethesda Hospital* case does not support plaintiffs' contention that patient telephones for non-intercom purposes are therapeutic and reimbursable.

The court recognizes that plaintiffs urge that this court has jurisdiction to decide the patient telephone issue because the PRRB found no jurisdictional bar to review an intermediary decision concerning a similar patient telephone issue in *Bethesda Hospital*. However, the PRRB interpreted a Centrex system as distinct from private, in-room patient telephones. The Centrex aspect of the telephone service did not constitute a § 1395y(a)(6) personal comfort item and, hence, § 1395*oo*(g) was not a jurisdictional bar for the PRRB in the Bethesda Hospital case.

[11] Only two courts have addressed the patient telephone reimbursement issue and both held that the Secretary had properly excluded patient telephones from medicare reimbursement. *See Presbyterian Hospital, supra; St. Francis Hospital v. Califano*, 479 F. Supp. 761 (D.D.C. 1979). However, neither court discussed the issue of whether there was a jurisdictional bar to review the patient telephone issue.

be reimbursable. However, the court is precluded by Congressional action from reviewing the patient telephone coverage issue and need not comment on the merits of the patient telephone issue.

B. *Method of Cost Allocation*

Plaintiffs urge that if the court affirms the PRRB's disallowance of plaintiffs' patient telephone costs that such disallowance be limited to the additional increment of cost to the basic hospital phone system incurred for patient in-room telephones.[12] The PRRB rejected plaintiffs' marginal or incremental costing method [13] and decided that a full or average costing method [14] should be utilized to determine the amount of plaintiffs' non-covered costs.

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[12] The Secretary concedes that the court has jurisdiction to review the method of cost allocation utilized by the Intermediary. The amount of disallowance is not a section 1395y determination that an item or service is non-reimbursable and, therefore, § 1395oo(g) does not preclude the court's review of the cost allocation method issue.

[13] Marginal or incremental costing would disallow only the additional costs related to telephone services used by patients for personal comfort purposes beyond those necessary to the basic hospital phone system. Under this approach, fixed overhead costs would be allocated to the hospital. This cost allocation would not change if patient telephones were added or deleted from the hospital phone system.

[14] Average or full costing includes all elements of cost by allocating a portion of the fixed overhead costs based on a variable statistic reflecting the ratio of patient telephones to the total number of telephones in the hospital.

The PRRB relied on 42 C.F.R. 405.451(b)(1)[15] and section 2106.1 [16] of the Provider Reimbursement Manual

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[15] 42 C.F.R. §405.451(b)(1) provides in pertinent part:

Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this subpart take into account both direct and indirect costs of provider of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program.

[16] Section 2106.1 of the Manual provides in pertinent part:

The *full* costs of items or services such as telephone, television, and radio which are located in patient accommodations and which are furnished solely for the personal comfort of the patients (full costs include costs both directly associated with personal comfort items or services plus an appropriate share of indirect cost) are not includable in allowable costs of providers under the Medicare Program. To illustrate, the full costs of telephones used solely for the personal comfort of patients include not only costs directly associated with these telephones, such as the rates billed by the public utility, but also an appropriate share of indirect telephone costs, e.g., operators' salaries, equipment, space-related costs of switchboard and other equipment, etc., as well as any other overhead that may be applicable thereto. (emphasis in original).

Plaintiffs argue that section 2106.2 of the Manual supports their incremental costing approach. Section 2106.2 provides in pertinent part:

Some nurse-patient communication systems based on closed circuit television are used in part for bringing in outside entertainment. Likewise, some patient communication systems operate through the telephone line and such a system may also be used, in part, by the patient for making or receiving outside calls.

Where providers use the combined systems, the basic cost of the components designed and used for patient care communication will be an allowable cost. Any incremental costs attributable to the additional components or capability for providing for the patient's entertainment or convenience are not allowable and must be excluded. Where this distinction cannot be clearly made, particularly as it applies to maintenance, the intermediary may approve an allocation covering these incremental costs (usually nominal) based on an equitable sharing.

(hereinafter "Manual") to support their full or average costing method conclusion. This decision reflects a choice of accounting procedures by the Secretary that is consistent with the Medicare Act and regulations. The Secretary has made one of many accounting choices necessary to determine the reasonable cost of services provided to Medicare patients. This is neither arbitrary or inconsistent with the law and must be upheld.

C. *Self-Disallowing Adjustments*

The PRRB ruled that it did not have jurisdiction over any "self-disallowing adjustments" [17] unless the costs had been claimed in the cost reports and the Intermediary subsequenlty made an adjustment disallowing such costs. Plaintiffs argue that they followed Medicare regulations and instructions [18] in completing their cost reports and thereby made their own disallowances by not claiming certain costs for reimbursement pursuant to these regulations and instructions. Plaintiffs contend that they should not be denied a right to be heard on these disallowances because: (1) the PRRB took jurisdiction over cost reports to review intermediary adjustments with respect to claimed costs and it should also have jurisdiction over costs that were subject to plaintiffs' self-disallowing adjustments in the same cost report, and (2) they complied with the Secretary's regulations and instructions in completing their cost reports.

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[17] Self-disallowing adjustments are decisions by hospitals not to claim certain costs for reimbursement in accordance with regulations and guidelines which prohibit reimbursement for certain costs. The intermediary does not have to adjust the hospital's cost reports to disallow claimed costs if the hospital has already made such self-disallowwoing adjustments.

[18] Plaintiffs followed cost report instructions and 42 C.F.R. §§ 405.420(c) and 405.452 which resulted in a self-disallowance of Hill-Burton costs. Plaintiffs also made self-disallowing adjustments for patient telephone costs pursuant to 42 C.F.R. § 405.310(j) and section 2106.1 of the Manual.

Plaintiffs' argument is based on 42 U.S.C. §§1395*oo*(a), (d).[19] Plaintiffs argue that they were "dissatisfied" with the "amount of total program reimbursement" and, therefore, met the statutory requirement for a PRRB hearing. 42 U.S.C. § 1395*oo*(a)(l)(A). In addition, plaintiffs contend their self-disallowing adjustments were subject to the PRRB's jurisdiction because the PRRB has jurisdiction over "matters [that] were not considered by the intermediary in making such final determination," 42 U.S.C. §1395*oo*(d), and plaintiffs' unclaimed costs constitute such matters.

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[19] 42 U.S.C. §§1395*oo*(a)(1)(A), (d) provide in pertinent part:

(a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section, if–

(1) such provider–

(A) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to § 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report,

. . . .

(d) A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

These arguments do not require the court to find that the PRRB should have exercised jurisdiction over plaintiffs' self-disallowed patient telephone costs. The Intermediary found that patient telephone costs were not reimbursable when these costs were claimed by plaintiffs. The PRRB and this court do not have jurisdiction to review this finding. 42 U.S.C. §1395oo (g). Therefore, it is unnecessary to remand the issue of the self-disallowed patient telephone costs which were not claimed by plaintiffs to the administrative level for further proceedings.

The self-disallowed Hill-Burton costs issue does require a remand to the administrative level for further proceedings. The Fifth Circuit decided these costs were reimbursable. *Presbyterian Hospital, supra.*[20] The PRRB has jurisdiction to review matters that were not considered by the Intermediary in making a reimbursement determination. 42 U.S.C. §1395oo(d). The self-disallowed Hill-Burton costs constitute such matters. Therefore, the self-disallowed Hill-Burton costs issue is remanded to the PRRB for proceedings consistent with this opinion.

D. *PRRB's Failure to Assert Jurisdiction over the Intermediary's Refusal to Reopen Cost Reports.*

Two plaintiff-hospitals [21] did not claim patient telephone and Hill-Burton expenses on their original 1974 and 1975 cost reports.[22] There was no appeal by these hospitals to the PRRB based on the intermediary's failure to reimburse them for these

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[20] It appears that the Hill-Burton costs in *Presbyterian Hospital* were claimed by the plaintiff and there was not a self-disallowing adjustment issue.

[21] Memorial Hospital of Sarasota and Bethesda Memorial Hospital appealed the PRRB's refusal to assert jurisdiction over the 1974 and 1975 cost reports issue.

[22] Reimbursement and cost issues discussed in this opinion have dealt with 1976 and 1977 cost years.

costs within the requisite 180 days of issuance of the Notice of Program Reimbursement (NPR), 42 U.S.C. § 1395*oo*(a)(3).[23] The Intermediary subsequently reopened [24] the 1974 and 1975

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[23] 42 U.S.C. § 1395*oo*(a)(3) provides:

(a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board" which shall be established by the Secretary in accordance with subsection (h) of this section, if–

. . . .

(3) Such provider files a request for a hearing within 180 days after notice of the interemdiary's final determination under paragraph (1)(A) or with respect to appeals purusant to paragraph (1)(B) or (C), within 180 days after notice of such had been made on a timely basis.

[24] The authority for the reopening of cost report determinations and decisions is set forth in 42 C.F.R. §405.1885 which provides in pertinent part:

(a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer or panel of hearing officers, Board, or Secretary, as the case may be, either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 years of the date of notice of the intermediary or Board hearing decision, or where there has been no such decision, any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provied in paragraphs (d) and (e) of this section.

cost reports to retroactively disallow special care units costs.[25] These two plaintiffs then appealed to the PRRB, within 180 days of the issuance of the revised NPR, the Intermediary's refusal to reopen the 1974 and 1975 cost reports for plaintiffs'

(b) A determination or a hearing decision rendered by the intermediary shall be reopened and revised by the intermediary if, within the aforementioned 3-year period, the Health Care Financing Administration notifies the intermediary that such determination or decision is inconsistent with the applicable law, regulations, or general instructions issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the intermediary.

(c) Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.

(d) Notwithstanding the provisions of paragraph (a) of this section, an intermediary determination or hearing decision, a decision of the Board, or a decision of the Secretary shall be reopened and revised at any time if it is established that such determination or decision was procured by fraud or similiar fault of any party to the determination or decision

. . . .

See also River Garden Hebrew Home v. Califano, 507 F. Supp. 221, 225-27 (M.D. Fla. 1980).

[25] The PRRB severed the special care units issue for the 1974 and 1975 cost years and treated it as a separated appeal.

patient telephone and Hill-Burton claims. The PRRB refused to assert jurisdiction over these claims.[26]

Plaintiffs contend that if the Intermediary could reopen the 1974 and 1975 cost reports for the special care units issue, then plaintiffs should have a right to be heard with respect to patient telephone and Hill-Burton costs for the same cost years.

In accordance with its findings and reasoning on the self-disallowing adjustments issue, this court agreed with the PRRB that it should not have asserted jurisdiction over plaintiffs' request to reopen the 1974 and 1975 cost reports on the patient telephone costs issue. The Intermediary found that such costs were not reimbursable when claimed by plaintiffs in their 1976 and 1977 cost reports. The PRRB and this court do not have jurisdiction to review this finding. 42 U.S.C. §1395*oo*(g). Therefore, it is unnecessary to remand the patient telephone issue which was not raised by these two plaintiffs in their 1974 and 1975 cost reports to the administrative level for further proceedings.

However, like the self-disallowed Hill-Burton costs adjustments, the Hill-Burton costs claim in the 1974 and 1975 cost reports must be remanded to the administrative level for further proceedings. *See Athen Community Hospital, Inc. v. Schweiker*, 514 F.Supp. 1336 (D.D.C. 1981). An Intermediary determination must be reopened if such determination is inconsistent with the applicable law. 42 C.F.R. §405.1885(b). The Fifth Circuit decided that Hill-Burton costs were reimbursable. *Presbyterian Hospital, supra*. These two plaintiffs satisfied the 180 day statute of limitations for requesting an appeal with the PRRB. 42 U.S.C. 1395*oo*(a)(3); 42 C.F.R. § 1889.[27] The

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[26] The PRRB did not address the reopened cost reports issue in its written decision, but orally denied jurisdiction to review such issue at the PRRB hearing.

[27] 42 C.F.R. § 1889 provides:

Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

PRRB has jurisdiction to review matters that were not considered by the Intermediary in making a reimbursement determination. 42 U.S.C. §1395*oo*(d). The Hill-Burton costs from the 1974 and 1975 cost reports constitute such matters. Therefore, the Hill-Burton costs issue from the 1974 and 1975 cost reports is remanded to the PRRB for proceedings consistent with this opinion. Counsel for plaintiffs will prepare and present, after endorsement by counsel for defendant, an appropriate final judgment to be entered by the Court, all of which shall be done within twenty (20) days from this date. If there is disagreement as to the contents of said order, counsel shall notify the Court by telephone and an immediate hearing date at Norfolk, Virginia will be scheduled.

Dated: Norfolk, Virginia
October 20, 1981.